



New Patient Questionnaire

Name: _____ Date: _____

Age: _____ DOB: _____

Reason you're being seen? _____

When did your symptoms first begin? _____

When (if so) did they get worse? _____

Severity of you symptoms? mild moderate severe

Are your symptoms: seasonal all year long all year long with seasonal worsening*

*Circle the worst months: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

What makes your symptoms worse?

Irritants	Weather	Medicine	Allergens	Location
<input type="checkbox"/> smoke <input type="checkbox"/> air pollution, fumes, or car, exhaust <input type="checkbox"/> strong odors, or perfumes	<input type="checkbox"/> cold air <input type="checkbox"/> rapid temperature change (going from cold outdoors to indoor heat)	<input type="checkbox"/> aspirin <input type="checkbox"/> non-steroid, anti-inflammatory agents (Motrin, Advil, Aleve)	<input type="checkbox"/> grass/tree/weeds <input type="checkbox"/> dust or vacuuming <input type="checkbox"/> damp/musty area <input type="checkbox"/> animals __dog __cat __other	<input type="checkbox"/> outdoors <input type="checkbox"/> indoors <input type="checkbox"/> daycare <input type="checkbox"/> home <input type="checkbox"/> school <input type="checkbox"/> work

Associated Symptoms

Chest <input type="checkbox"/> coughing <input type="checkbox"/> wheezing <input type="checkbox"/> shortness of breath <input type="checkbox"/> trouble breathing with exercise <input type="checkbox"/> trouble breathing at night	Nose <input type="checkbox"/> nasal congestion <input type="checkbox"/> runny nose <input type="checkbox"/> sneezing <input type="checkbox"/> post nasal drip <input type="checkbox"/> itchy nose <input type="checkbox"/> loss of taste or smell	Sinus <input type="checkbox"/> sinus pain / pressure <input type="checkbox"/> recurrent sinus infection <input type="checkbox"/> yellow / green drainage <input type="checkbox"/> nasal or sinus surgery	GI <input type="checkbox"/> heartburn <input type="checkbox"/> belching <input type="checkbox"/> trouble swallowing <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea	Eyes <input type="checkbox"/> itchy eyes <input type="checkbox"/> watery eyes <input type="checkbox"/> swelling of eyelids <input type="checkbox"/> redness of eyelids	Ears <input type="checkbox"/> ear congestion <input type="checkbox"/> ear blockage <input type="checkbox"/> hearing loss <input type="checkbox"/> recurrent infections <input type="checkbox"/> popping or clicking	Skin <input type="checkbox"/> itchy skin <input type="checkbox"/> eczema <input type="checkbox"/> hives / welting <input type="checkbox"/> swelling <input type="checkbox"/> rash
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Other: _____

Do you know of any blood relatives who have or had the following? Please check and give relationship

<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Thyroid disease _____
<input type="checkbox"/> Allergic rhinitis/hay fever _____	<input type="checkbox"/> Angioedema _____
<input type="checkbox"/> Food, allergies _____	<input type="checkbox"/> Hives _____
<input type="checkbox"/> Atopic dermatitis/eczema _____	

Review of Systems

<p>General</p> <input type="checkbox"/> Weight Loss <input type="checkbox"/> Emotional Problems <input type="checkbox"/> Missed School/Work <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Night Sweats	<p>Headaches</p> <input type="checkbox"/> Frontal <input type="checkbox"/> Maxilla <input type="checkbox"/> Temporal	<p>Throat</p> <input type="checkbox"/> Frequent Infections <input type="checkbox"/> Clearing Frequently <input type="checkbox"/> Bad Breath <input type="checkbox"/> Voice change <input type="checkbox"/> Sore Throat <input type="checkbox"/> Hoarseness	<input type="checkbox"/> Swollen Glands <input type="checkbox"/> Tonsil or Adenoids removed (age) _____
<p>GU</p> <input type="checkbox"/> Infection <input type="checkbox"/> Blood in urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Burning Urination	<p>MS</p> <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Joint Pain <input type="checkbox"/> Arthritis	<p>Neuro</p> <input type="checkbox"/> Tingling/Numbness <input type="checkbox"/> Fainting <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Meningitis	<p>Psych</p> <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Stress
<p>Other: _____</p>			

Food Allergy: None If yes, describe _____

Latex Reactions: None Gloves Balloons Dental Visits Vaginal Exams Kiwi Banana

Bee Sting: None Never Stung Local Swelling Respiratory Other

Social History

Marital Status: single married divorced widowed separated partner

Occupation/Job/School: _____

Smoking status: yes no (current smoker number of years: _____ packs per day: _____)

Secondhand smoke exposure: yes no

Pets in home: (circle) dog cat rabbit hamster guinea pig other: _____

Housing: house apartment urban suburb farm/rural

Heating: gas electric wood burning steam heat

A/C: central A/C window A/C none

Humidifier: room central none

Bedding: Pillow: feather/down synthetic Comforter: feather/down synthetic

Flooring: Bedroom: carpet tile wood House: carpet tile wood

Hobbies/sports: _____

Check any of the illnesses/medical conditions that you have had

- | | | | |
|----------------------------------------------|---------------------------------------------------|---------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Irritable bowel |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Headaches | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart attack/angina | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Heartburn/acid reflux |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Atopic dermatitis/eczema | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psoriasis |

Other: _____

List all surgeries/operations/hospitalizations: _____

What medication have you tried for your allergy problems in the past? Has it been effective?

Are you allergic to any medication? If so, list drug, type of reaction and when

Number of courses of antibiotics in past 12 months: _____

List all prescription and over-the-counter medications you are currently using

Name	Dosage

Physician: _____ **Date:** _____

